LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
CLIENT STATEMENT

DMH Policy #404.1

Attachment I

DATE_____

PATIENT PAYMENT CARD

MIS NUMBER_____

CLIENT

RESPONSIBLE PERSON

ADDRESS

CITY, STATE, ZIP CODE

THIS STATEMENT INCLUDES ALL CHARGES AND CREDITS THROUGH_____

AMOUNT NOW DUE_____

PLEASE ENTER AMOUNT PAID_____

CUT ✂ ON DOTTED LINE — RETURN THE TOP PORTION WITH YOUR PAYMENT

SERVICES

PAYMENT DUE

MONTH	SERVICES PROVIDED* I	G	M	P		TOTAL U'S	COST OF CARE THIS MONTH	AMOUNT DUE LAST MONTH	PAYMENTS AND ADJUSTMENTS**	PAYMENT PLAN AMOUNT DUE THIS MONTH***	TOTAL AMOUNT DUE THIS MONTH

UMDAP PERIOD

_____ TO _____

ANNUAL LIABILITY_____

*SERVICE CODES

I - Individual

G - Group

M - Medication

P - Psych. Emergency

**PMT & ADJ CODES

C - CHAMPUS
E - Error Correction
I - Insurance
M - Medicare
P - Patient Payments
T - Therapeutic Fee Adjustment
U - UMDAP Billing Adjustment

***PAYMENT PLAN

DATE	AMOUNT	COMMENTS

If you have a question or problem about this statement, please call or visit the clinic billing office as soon as possible.

Make your Check or Money Order Payable To:
LAC-DEPT. OF MENTAL HEALTH

Please Do Not Send Cash

— Thank You —

MH-002F

UMDAP WORKSHEET

DMH Policy #404.1

Client Name _____

UMDAP Period _____ To _____

Annual Liability $ _____

MONTH	Cost of Care	Cumulative Cost of Care	Beginning UMDAP Balance	Payments Received	Pmt. Type*	Receipt No.	Adjustments	Adj. Type*	New UMDAP Balance

*Payment & Adjustment Codes

C - CHAMPUS
E - Error Correction
I - Insurance
M - Medicare
P - Patient Payment
T - Therapeutic Fee Adj.
U - UMDAP Billing Adj.
W - Write Off